Dumfries and Galloway
Integration Joint Board

06th August 2020

This Report relates to
Item 7 on the Agenda

Sustainability and Modernisation Programme Update

Paper presented by David Rowland

For Noting

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List of Background Papers:	Sustainability and Modernisation Programme Update 21 October 2019
Appendices:	**Appendix 1 –** **Sustainability and Modernisation Programme: 2020/21**

Direction Required to Council, Health Board or Both	**Direction to:**	
	1. No Direction Required	✓
	2. Dumfries and Galloway Council	
	3. NHS Dumfries and Galloway	
	4. Dumfries and Galloway Council and NHS Dumfries and Galloway	

1. Introduction

1.1 This report sets out the focus and scope of the Sustainability and Modernisation (SAM) Programme for Financial Year 2020/21. Members of the Integration Joint Board are asked to note the content of this report and offer guidance and direction on any further priorities for inclusion in this year's programme.

2. Recommendations

2.1 **The Integration Joint Board is asked to:**

- **Note the initial focus and scope of the SAM Workplan for 2020/21;**
- **Consider the extent to which this supports delivery of the Strategic Plan;**
- **Determine any further or alternative priorities for the SAM Programme in 2020/21.**

3. Background and Main Report

3.1 The Sustainability and Modernisation Programme (SAM) was established in response to the significant financial challenges faced by the Health and Social Care Partnership and NHS Dumfries & Galloway.

3.2 SAM will engage with the wider partnership to design, define and support the delivery of a time bound programme of work that will modernise, sustain and deliver a financially viable model for Health and Social Care Services, in line with the agreed Strategic and Annual Operational Plan.

3.3 SAM projects must clearly demonstrate one or more of the following characteristics:

- Recognises financial improvement initiatives that could be a result of operational, clinical and financial actions
- Potential to deliver measurable, sustainable and recurrent outcomes
- Creates fluidity and capacity in the system by making the current processes more effective, efficient and productive
- Demonstrates feasibility from a resource and data standpoint
- Offers redesign, development and service change to deliver better outcomes

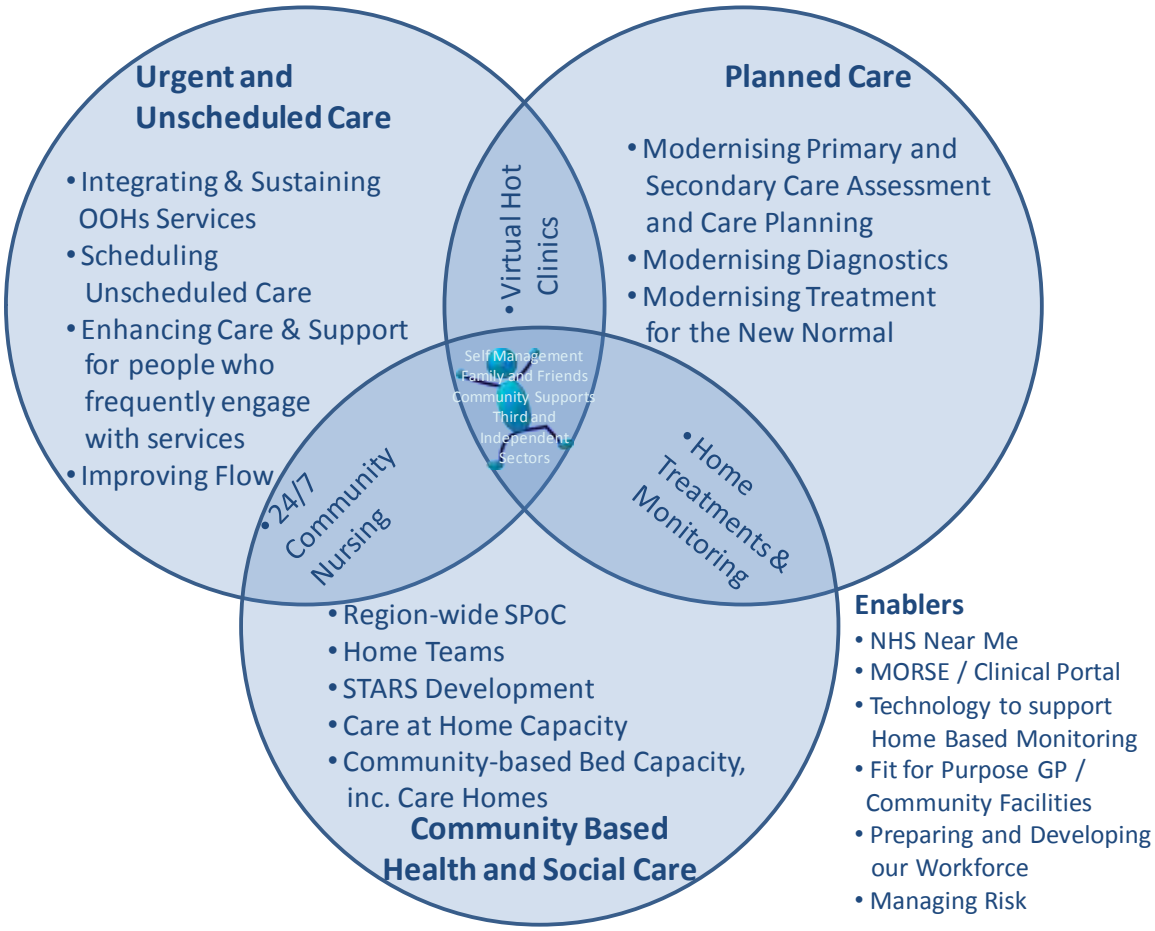
3.4 It is proposed that for 2020/21, the SAM programme should focus on three key elements of care:

1) planned care, including assessment, diagnostics, care planning and treatment;
2) urgent and unscheduled care, including in-hours and out of hours GP services; and
3) community health and social care, with a focus on sustaining social support and developing Home Teams.

3.5 In doing so, it is clear that there is a need to put the person who needs assessment, treatment, care and support at the centre and ensure they, along with their family, friends and informal support networks are empowered to effectively and safely manage their condition and care for themselves.

3.6 Further, it is proposed that these areas are supported by the development of key enablers such as technology to support independent living, information sharing and early identification of needs.

3.7 This is summarised as follows:



3.8 Full details of these proposals, the governance arrangements that underpin them and the progress being made against each of them are set out within ***appendix 1***.

4. Conclusions

4.1 Given the wide potential scope of SAM, a focused programme of initial priorities has been defined and these will be prioritised and scheduled in line with the SAM process as set out in **appendix 1**.

4.2 SAM will engage with the wider partnership to design, define and support the delivery of this programme that will modernise, sustain and deliver a financially viable model for Health and Social Care Services, aligned with the priorities of the Strategic Plan.

4.3 Progress against the SAM Programme will be reported routinely to the Health and Social Care Governance and Performance Group, with regular updates to the IJB and NHS Board through the associated governance committees.

5. Resource Implications

5.1 The prime focus of the SAM Programme is the redesign and transformation of services in Dumfries and Galloway to ensure local people continue to access high quality, responsive assessment, treatment, care and support while addressing the

underlying financial pressures across the Health and Social Care System.

5.2 At this time, the subjects of this report require no additional resource beyond that already allocated to staff the Programme Team. .

5.3 That said, should any element of the programme require initial investment on a 'spend to save' basis, this will be highlighted to Members of the Integration Joint Board at the earliest possible stage, along with proposals from where that funding would be allocated and the anticipated benefits.

6. Impact on Integration Joint Board Outcomes, Priorities and Policy

6.1 SAM aims to align with the national health and wellbeing outcomes and the local 10 priority areas set out by the Health and Social Care Strategic Plan. Specifically SAM will contribute to;

- Developing and strengthening communities
- Shifting the focus from institutional care to home and community based care
- Integrated ways of working
- Working efficiently and effectively
- Making the best use of technology

7. Legal and Risk Implications

7.1 While there are no legal implications associated with the focus and scope of the SAM Programme, there are significant risks for the Integration Authority should the programme not be delivered. These include:

- Continued underlying financial pressures, which may result in an inability to deliver services in line with local needs and / or to the standards desired by the Integration Authority;
- Continued provision of traditional models of care that cannot offer the capacity to meet local needs and demands associated with normal winter pressures;
- Continued workforce pressures that exacerbate the financial position and limit service capacity;
- Continued delivery of service models that unnecessarily risk exposure of those who use and provide services to Covid-19; and
- Continued focus on hospital based care for people of complex co-morbidities, resulting in increased levels of dependence and reliance on long-term care and support.

8. Consultation

8.1 The content of the programme described within this paper has been developed through direct engagement with the staff and services that have been included. The broad concepts contained within the programme have been explored with wider staff groups and agreed by the Health and Social Care Senior Management Team. The proposed approach was also shared with Members of Dumfries and Galloway Health Board at a recent briefing session for Non-Executive Board Members.

8.2 Wider consultation will be required on the constituent elements of the SAM Programme.

9. Equality and Human Rights Impact Assessment

9.1 This programme represents a framework under which the focus and efforts of the SAM Programme Team will be co-ordinated in 2020/21. While, as a planning tool, this framework does not require an Equalities Impact Assessment (EQIA), it will be necessary to assess whether one is required for each element of the workplan and where that is the case, ensure its timely completion.

10. Glossary

10.1 All acronyms must be set out in full the first time they appear in a paper with the acronym following in brackets.

EQIA	**Equalities Impact Assessment**
IJB	**Integration Joint Board**

Dumfries and Galloway Integration Joint Board

DIRECTION

(ISSUED UNDER SECTIONS 26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014)

1.	Title of Direction and Reference Number	
2.	Date Direction Issued by Integration Joint Board	
3.	Date from which Direction takes effect	
4.	Direction to	
5.	Does this direction supersede, amend or cancel a previous Direction? If yes, include the reference number(s)	
6.	Functions covered by Direction	
7.	Full text of Direction	
8.	Budget allocated by Integration Joint Board to carry out Direction	
9.	Desired Outcomes	
10.	Performance Monitoring Arrangements	
11.	Date Direction will be Reviewed	

Sustainability and Modernisation Programme

The Sustainability and Modernisation Programme (SAM) was established in response to the significant financial challenges faced by the Health and Social Care Partnership and NHS Dumfries & Galloway.

Dumfries and Galloway Health and Social Care Partnership needs to be assured that the available budget is being used wisely. At the same time, the Partnership needs to encourage all partners and staff to talk openly about the challenges being faced whilst working proactively to protecting the quality of services that have been delegated.

This is key to ensuring that local people are supported to achieve their desired outcomes.

It was initially determined that in Dumfries and Galloway this approach would take the form of a financial improvement programme focusing on sustainability and subsequently targeting pieces of work involving redesigns, modernisation and transformation of services whilst ensuring team engagement in harnessing the principles of 'compassionate leadership'.

While the principles of this approach still hold, it has been recognised that effective and sustained staff and partner engagement must be underpinned by a real sense of what this will achieve for local people and how services can be transformed to support this.

On that basis the SAM Programme has been refreshed, with the intelligence gathered through the SAM Ideas aligned with wider intelligence about organisational performance and pressures, as well as learning from the local response to Covid-19 to inform a refreshed programme of work for 2020/21.

Aim Statement

SAM aims to promote and drive transformational change in delivering our services in the most efficient way and, crucially, by capturing and measuring the benefits - whether that be quality, productivity or financial.

SAM will engage with the wider partnership to design, define and support the delivery of a time bound programme of work that will modernise, sustain and deliver a financially viable model for Health and Social Care Services, in line with the agreed Strategic and Annual Operational Plan. SAM will:

- Increase the probability of delivery against each project
- Improve the capture and accuracy in appraising the overall project benefits
- Enable spread from successful projects at pace across the Partnership

In doing so SAM will draw on proposals from operational Directorates and undertake horizon scanning to identify opportunities for change, combining these where appropriate into consolidated, collaborative whole system programmes.

What makes a SAM Project?

SAM projects must clearly demonstrate one or more of the following characteristics:

- Recognises financial improvement initiatives that could be a result of operational, clinical and financial actions
- Potential to deliver measurable, sustainable and recurrent outcomes
- Creates fluidity and capacity in the system by making the current processes more effective, efficient and productive
- Demonstrates feasibility from a resource and data standpoint
- Offers redesign, development and service change to deliver better outcomes

Operational changes that are straightforward in nature, with clear cause and effect, will be managed and implemented at directorate level with oversight from the Health and Social Care Operational Group.

Teams proposing projects to be progressed through the SAM Programme will enter into an agreement through a defined SAM process based on project management principles and will be responsible for the delivery of their project.

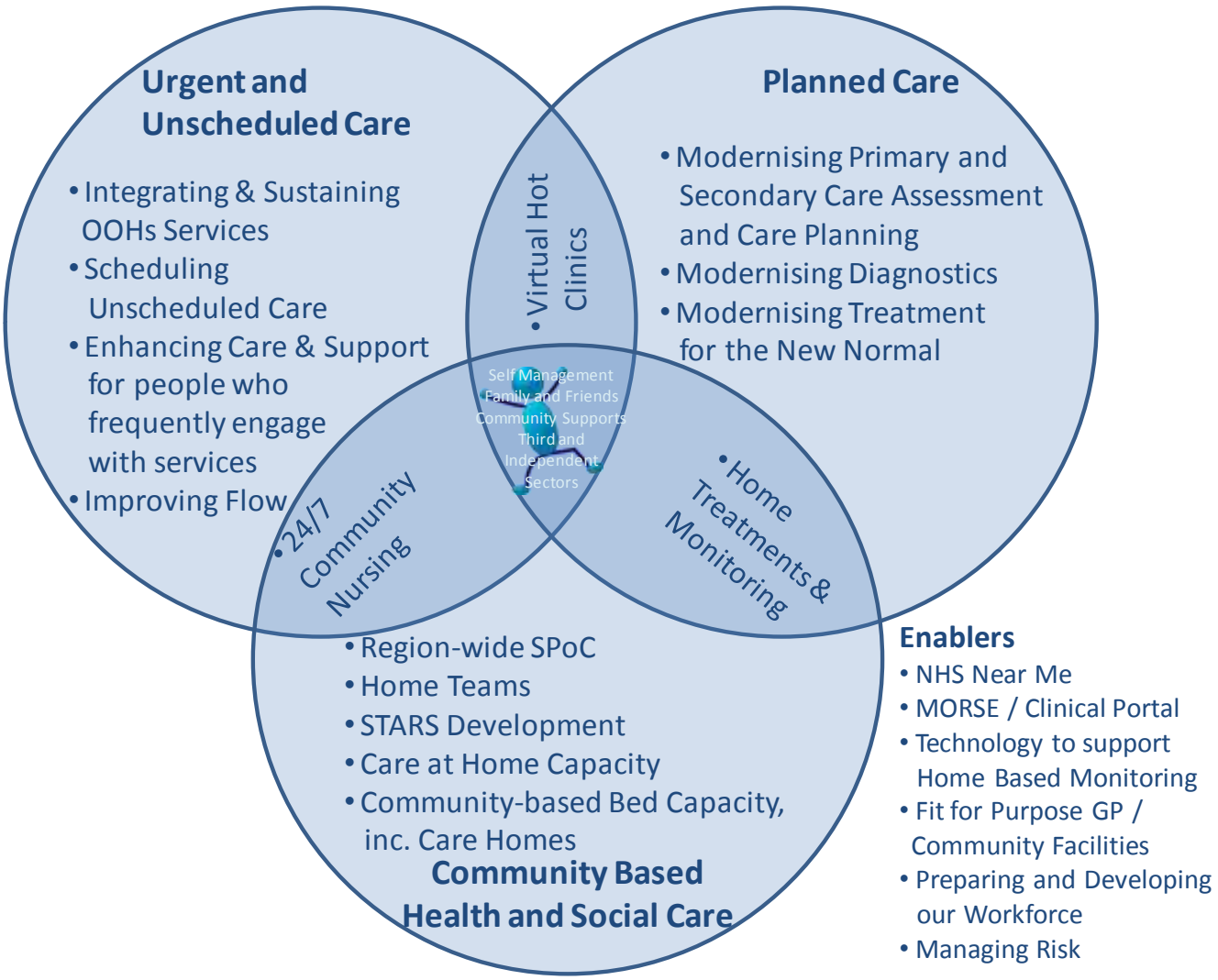
Each project will be required to capture and articulate the aim, scope, deliverables, impact, timescales and responsible officers of the proposed change against which teams will be held to account in line with agreed outcomes. Projects will be subject to a robust approval processes prior to commencement.

Initial Priorities

Recognising the financial challenges facing Dumfries and Galloway Health and Social Care Partnership in 2020/21, the SAM Programme must, in the first instance, identify those major impact changes that will begin to demonstrate a move back to financial sustainability. Thereafter, attention will turn to the modernisation opportunities that will develop models of care that support people to achieve their desired outcomes, offer high quality care and complete the financial transformation for the organisation.

Early thinking suggests that the programme should focus on three key elements of care – 1) planned care, including assessment, diagnostics, care planning and treatment; 2) urgent and unscheduled care, including in-hours and out of hours GP services; and 3) community health and social care, with a focus on sustaining social support and developing Home Teams.

In doing so, it is clear that there is a need to put the person who needs assessment, treatment, care and support at the centre and ensure they, along with their family, friends and informal support networks are empowered to effectively and safely manage their condition and care for themselves. Further, it is proposed that these areas are supported by the development of key enablers such as technology to support independent living, information sharing and early identification of needs. This approach is depicted in the diagram below:



A little more detail on each of the service areas is set out below:

Planned Care
This programme will support elective services to assess and balance the risks associated with potential exposure of patients to Covid-19 with the wider risks associated with their underlying conditions. Through this programme, end-to-end elective care pathways will be developed to ensure that safe and effective assessment, care planning, treatment and support is available to those who need access to them, including the identification and application of more conservative management approaches as a norm.

Recognising the importance of promoting and supporting social distancing, this programme will introduce new models of care that offer viable alternatives to traditional approaches in order to minimised the risk of potential exposure to Covid-19 for patients and staff.

The requirement to develop and deliver such new models presents an opportunity to move elective care in Dumfries and Galloway into a more sustainable state where the capacity available is prioritised towards those who are likely to derive maximum benefit, while promoting self-management and multidisciplinary working to offer community-based care plans where appropriate.

With that in mind, this programme will be focused on delivering the ambition set out in the Healthcare Quality Strategy for NHS Scotland, namely that:

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

In doing so the programme will establish a consistent, tiered approach for pathway development across all elective services that:

- Promotes and supports self-management and self-care
- Enables General Medical Practitioners to develop and manage more comprehensive care plans in community settings
- Supports the tailoring and targeting of care planning to individual needs by routinely connecting General Medical Practitioners and Specialist Medical and Nursing Teams
- Recognises the importance of social distancing when Specialist Medical and Nursing Teams need to engage directly with patients, promoting: telephone and NHS Near Me consultations as the new normal, with face-to-face consultations only where absolutely necessary
- Encourages the use of diagnostic testing in line with the principles of Realistic Medicine and only where there is a strong likelihood it will change a management plan
- Establishes clear and consistent thresholds for treatment based on the value any given treatment would add to a patient's outcome, offering the clinician the ability to:

    - Discharge the patient from acute care with a management plan
    - Discharge the patient from acute care with a management plan and clear criteria for patient initiated review
    - Keep the patient on the waiting list for a non-urgent treatment or
    - Place the patient on the waiting list for urgent treatment
    - This work will began in early June 2020 with an engagement session for senior medical, nursing and AHP staff
        - to develop the risk management framework that will underpin it
        - agree the principles that will be applied in developing the new pathways and
        - determine the initial priority areas for action based on an analysis of the Discovery Data and the Scottish Atlas of Healthcare Variation

In the first instance, the focus will be on the development of pathways designed to:

- Enhance community-based care and support for individuals with a diagnosis of Dementia;
- Reduce the number of unnecessary review out-patient appointments in Ophthalmology;
- Ensure people who are currently referred to Orthopaedics secure access to the right person, first time; and
- Reduce the number of procedures that offer no or limited improvement in outcomes for patients.

Detailed proposals for each of these priorities, along with anticipated impact on referrals, activity and waiting lists, are currently being developed by the respective services. These will be subject to clinical review and testing by the Oversight and Scrutiny Group before being signed-off for implementation.

Further priorities will be identified for modernisation based on a review of local data, an assessment national benchmarking data and opportunities identified by local teams.

Unscheduled Care

Direction is emerging for the need to develop a consistent approach for access to unscheduled care across Scotland that builds on the lessons from the Covid-19 Assessment Hub Model.

It is anticipated that by October 2020 an unscheduled care hub will need to be established in Dumfries and Galloway to receive triaged calls from NHS 24 and offer local clinical triage, telephone advice and, where necessary, scheduled access to a 24/7 Multi-Disciplinary Team. In the first instance, it is expected that this pathway will focus on meeting the needs of those who self-present to the Emergency Department.

This emergent national direction fits with the wider scope that has been identified by local clinicians and managers for the unscheduled care element of the SAM Programme and. This scope, which is now being prioritised and scheduled, is set out below:

Priority	Rationale	Aim	Benefit for the person	Professional Benefit	Risk Benefit	Operational Benefit	Financial Benefit
Developing a more integrated approach to OOHs Service Delivery across Primary, Community and Secondary Care	People who have the most complex needs and present to GP OOHs, Social Work OOHs, Scottish Ambulance Service and the Emergency Department can have a disjointed journey through services with multiple hand-offs and / or referrals, with a mis-match between capacity and demand, a disconnect between in-hours and out-of-hours care and elements of the system being very medically focused	An affordable, sustainable multi-disciplinary OOHs service where the Senior Clinical Decision Maker role is complemented by the skills, experience and expertise of a Social Worker and / or Mental Health Officer are readily available along with those of physical and / or mental health teams to contribute to the assessment and care planning of those who present, including those with the most complex needs and those who may be experiencing child or adult protection issues. This team will offer high quality interventions in line with the person's expressed wishes and preferences as recorded in their Anticipatory Care Plan where one exists, while initiating an anticipatory care planning discussion, including a discussion about ceilings of care, where this is appropriate.	Improved Accessibility; Access to person with skills matched to need; Enhanced continuity and consistency of care; provision of more holistic care and support to enable people to stay safely at home	Skillsets matched to need; reduced duplication and unnecessary hand-offs; Opportunities to develop skills and competencies that support re-validation	Individuals less likely to 'fall between cracks'; Individuals directed to right service based on need; Improved level and quality of care for people who need support at home; improved rota cover	Services can be better configured and delivered with the right capacity and skillsets available to meet needs; reduced rota management	Potential to reduce inappropriate admissions and experience return visits as individuals can access the professional with the skills, expertise and experience best matched to their needs

Priority	Rationale	Aim	Benefit for the person	Professional Benefit	Risk Benefit	Operational Benefit	Financial Benefit
Integrating in-hours unscheduled care with Social Work Duty services and other community based care	People who have the most complex needs and present to GP Practices, Social Work Access, Scottish Ambulance Service and the Emergency Department can have a disjointed journey through services with multiple hand-offs and / or referrals	A multi-disciplinary approach to in-hours unscheduled care that sees people directed to the service most appropriate to their needs, including General Practice, Community Pharmacy, building on the Pharmacy First Model; Optometry; Dentistry; and Hospital Based Care, with rapid access to the skills, experience and expertise of a Social Worker, along with those of the wider Home Team, to contribute to the assessment and care planning of those with the most complex needs, as well as to lead the team in responding to public protection issues	Improved Accessibility; Access to person with skills matched to need	Skillsets matched to need; reduced duplication and unnecessary hand-offs; Opportunities to develop skills and competencies that support re-validation	Individuals less likely to 'fall between cracks'; Individuals directed to right service based on need	Services can be better configured and delivered with the right capacity and skillsets available to meet needs	Potential to reduce inappropriate admissions and experience return visits as individuals can access the professional with the skills, expertise and experience best matched to their needs

Priority	Rationale	Aim	Benefit for the person	Professional Benefit	Risk Benefit	Operational Benefit	Financial Benefit
Scheduling Unscheduled Care	The current model of undifferentiated illness presenting to ED and GP OOHs does not support the goal of right care, in the right place, at the right time, nor does it enable social distancing within the waiting areas at times of peak demand	A sustainable model that ensures the skills, expertise and experience of a Senior Clinical Decision Maker are available to provide local triaging, advice and appointing of people who self-present to unscheduled care service, ensuring all available information and intelligence, including that contained within the person's Anticipatory Care Plan, are accessed and used to inform decision-making	Improved Accessibility; Access to person with skills matched to need; Reduced need for unnecessary travel	Skillsets matched to need; reduced duplication and unnecessary hand-offs; Opportunities to develop skills and competencies that support re-validation	Individuals directed to right service based on need	Service capacity can be better configured to needs	Potential to reduce avoidable admissions
Better meeting the needs of those who present frequently to unscheduled care services	The current model responds episodically to the needs of individuals with complex conditions and / or chaotic lifestyles who self-present to unscheduled care services, resulting in multiple and frequent attendances where long-terms needs are not fully assessed and / or planned for	Building on the work undertaken by the Emergency Department, a model that offers a targeted and holistic approach to engaging with people who present frequently to unscheduled care services and ensures their needs are assessed and the right professional with the right skills is available at the right time to support them and adopt a more planned approach to meeting their needs	Improved Accessibility; Access to person with skills matched to need; Reduced need for unnecessary travel	Skillsets matched to need; reduced duplication and unnecessary hand-offs; Opportunities to develop skills and competencies that support re-validation	Individuals directed to right service based on need	Service capacity can be better configured to needs	Potential to reduce avoidable admissions

Priority	Rationale	Aim	Benefit for the person	Professional Benefit	Risk Benefit	Operational Benefit	Financial Benefit
Reducing avoidable admissions from Care Homes	The Discovery dataset confirms that emergency admissions from Care Homes is one of the top five Ambulatory Case Sensitive Conditions that could be managed in a different way	A model that offers rapid access for Care Home staff to the skills and expertise offered by Home Teams and wider community based services, ensuring the skills and competencies required to support people to remain in a homely setting for longer, in line with the agreed wishes, outcomes and actions specified within their Anticipatory Care Plan, are readily and reliably accessible	Improved Accessibility; Access to person with skills matched to need; Reduced need for unnecessary travel	Skillsets matched to need; reduced duplication and unnecessary hand-offs; Opportunities to develop skills and competencies that support re-validation	Individuals directed to right service based on need	Service capacity can be better configured to needs	Potential to reduce avoidable admissions
Timely Discharge	The current model results in afternoon and early evening discharge as the norm	A model of multi-disciplinary approach to discharge that supports people to return home early in the day and at weekends, with appropriate updates made to their Anticipatory Care Plan, ensuring any changes to their wishes and preferences expressed during their hospital stay, including in relation ceilings of care, are fully recorded and updated	Improved understanding of when discharge will take place; direct discharge from the ward; reduced time spent unnecessarily in hospital	Greater predictability in available bed capacity	Reduced length of stay in CAU and ED	Bed capacity available to support the needs of those with greatest acuity; improved hospital flow	Reduced reliance on winter beds

Priority	Rationale	Aim	Benefit for the person	Professional Benefit	Risk Benefit	Operational Benefit	Financial Benefit
Managing Risk at the Hospital / Community Interface	The current model often results in the over-prescription of care at the point of discharge from hospital and the corresponding reluctance to effectively manage risk for individuals being discharged can result in delays in the transfer of their care and their prioritisation over those in the community, some of whom may be at greater risk.	A programme of support and development across hospital and community teams that reflects a person's expressed preferences and wishes, as recorded in their Anticipatory Care Plan, and promotes discharge to assess; ensures those with the appropriate skills, knowledge and experience lead that assessment process; supports the effective management of risk associated with this; and reduces inequity amongst those waiting for care and support while building on existing pathway development such as the Falls Pathway with Scottish Ambulance Service	Improved understanding of when discharge will take place; direct discharge from the ward; reduced time spent unnecessarily in hospital	Ability to assess a person's longer-term care and support needs at home, within familiar surroundings	Reduced length of stay in hospital	Bed capacity available to support the needs of those with greatest acuity; improved hospital flow; potential for reduced or delayed care at home or residential placements	Reduced reliance on winter beds

Priority	Rationale	Aim	Benefit for the person	Professional Benefit	Risk Benefit	Operational Benefit	Financial Benefit
CAU Operating Model	The current model struggles to offer sufficient capacity to respond to winter pressures	The development of an operating model that fully embraces and recognises the use of information on wishes and preferences as expressed in the Anticipatory Care Plan and ensures the resources of CAU are targeted at those most likely to return home after a short period of assessment, while fast-tracking those who are likely to need a prolonged hospital stay to the facility best placed to meet their needs	Access to the hospital facility best suited to meet needs	Reduced duplication and unnecessary hand-offs	Patient directed to most appropriate facility based on needs; Reduced length of stay in ED	Improved hospital flow and compliance with national targets and standards	Reduced reliance on winter beds

Community Health and Social Care

The key area of transformation within community health and social care services will be the adoption of the principles of Home First and Discharge to Assess through the development of fully integrated teams at a local level. These new Home Teams will comprise a cohesive, autonomous and self-directed group of professionals and support staff. Under the local direction of a Team Leader, the Home Team will be empowered, valued and motivated to come together to assess, treat, care for and support people in their own homes or in a homely setting.

In doing so, Home Teams will:

- Place the person at the heart of decision making about their condition and preferences
- Support people to take responsibility for these and self-manage with support from family, friends and social networks where necessary
- Link people with wider community-based services in line with their needs and preferences
- Adopt a preventative, early intervention approach to minimise the likelihood of crisis by co-ordinating more formal services to offer the assessment, treatment, care and support people need, whether short-term or long-term, when their needs increase
- Ensure consistency and continuity of team members involved in a person's care, with those members assuming responsibility for all aspects of that care as far as their skills and competencies allow
- Support people to maintain, regain and sustain independent living at home or in a homely setting

These teams will engage directly with GP Practices within their local areas to proactively identify and jointly manage those with the most complex conditions and care needs, minimising the future need for hospital admission and supporting their early discharge when an acute stay is necessary. In doing so, Home Teams will offer:

- Assessment and care planning by one or more professionals with an appropriate skills match to the person's symptoms / condition / life circumstance / personal outcomes
- Quick responding short-term treatment, care and support, including intermediate care and reablement
- Signposting to informal services and groups in the local community
- Targeted, person-centred advice, support and interventions designed to improve health, outcomes and opportunities at an individual level and contributing to improved population health and reduced health inequalities
- Links to more specialist assessment, treatment and support when needs change significantly
- Community rehabilitation
- Long term care, treatment and/or support
- Admission planning where a hospital stay would be beneficial, including clarity of the 'ask' of the hospital team
- Discharge planning for those admitted to hospital to establish the support necessary to return home with a view to completing treatment plans in the community

The introduction of these teams will be complemented by the rollout of a Single Point of Contact in Dumfries and Galloway, co-locating and fully integrating the Social Work Access Service and NHS Single Point of Contact (SPOC) to offer:

- Single point of entry to health and social care for local people and professionals
- Initial assessment and triage to Home Teams for people new to service and to Regional Services
- Rapid access to senior professional decision-maker, including mental health, wherever necessary to ensure presenting needs are fully assessed and individuals are appropriately directed to statutory services or informal community supports
- Streamlined, person-centred journeys with delays attributable to referrals and hand-offs minimised or removed
- Region-wide overview of patient flow

Further, the learning drawn from the shielding work will be reflected in plans for transforming community health and social care services with a view to developing greater community cohesion, capacity and resilience, in terms of the provision of social support. This will be vital to ensuring people continue to be connected with and supported by their local communities in order to mitigate the risk of social isolation, particularly as social distancing measures continue.

The initial, high level model for Home Teams and plans for rollout of the Single Point of Contact across Dumfries and Galloway has been approved by the Health and Social Care Senior Management Team. In doing so, agreement was reached that the model would be delivered in four Early Adopter sites in the first instance, namely the Machars, Southern Stewartry, Mid- and Upper Nithsdale and Moffat and Langholm.

Work is now underway at a locality level to establish these teams and draw learning with a view to refining and developing the model for rollout across the region in late Summer / early Autumn 2020. Crucially, the learning from these Early Adopter sites, with their focus on supporting people at home, will inform the future community-based bed capacity that will be required in each Locality.

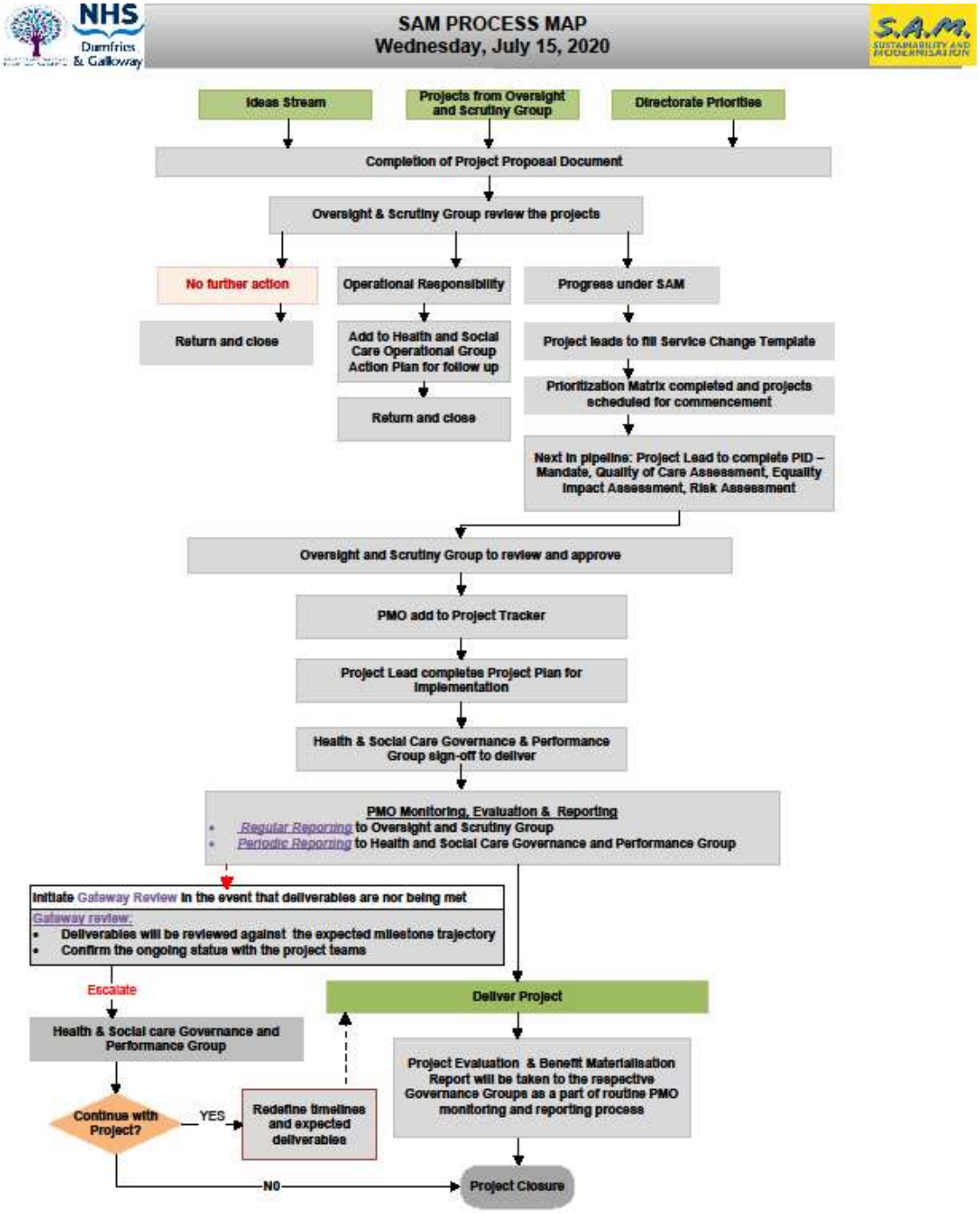
Programme Scrutiny and Oversight

Plans for the remodelling and modernisation of pathways in Dumfries and Galloway across the 3 areas outlined above will be assessed in terms of their anticipated impacts on quality, equality and finance by the newly formed, professionally-led Oversight and Scrutiny Group. This group will formally endorse any proposed changes before they are progressed.

To inform their decision-making the Scrutiny and Oversight Group will support the operational teams who are bringing forward change through the SAM Programme to complete a Service Modernisation Template. A copy of this template is set out at ***Annex A*** and, when completed, will help the Scrutiny and Oversight Group to better understand the nature of the change and its anticipated impact.

This will then be used by the Group Members to prioritise the projects within the SAM Programme, ensuring focus is given to those likely to deliver maximum benefit while avoiding any one service area or Directorate being asked to deliver more change than it has capacity for. The Prioritisation Matrix that group members will use is set out at ***Annex B***.

The following diagram summarises the governance around this decision-making process:



Specifying Anticipated Benefits

With the original purpose in mind, work is now underway to quantify the anticipated benefits associated with each element of the SAM Programme. These will be formally captured in the SAM Mandate in terms of those that are of particular interest to the programme in terms of anticipated savings and costs avoided, as well as those that will be of interest to the service in terms of quality improvement and performance.

Programme Monitoring, Review and Update

When these benefits have been fully defined work will begin to closely monitor progress against the specified trajectories and it is anticipated that the first report will be available by the end of September 2020.

Thereafter, progress will be monitored and reviewed to determine when projects should be considered to be operating on a business as usual basis, which continue to require SAM input and which should be concluded and learning drawn to inform future work.

At the same time, work will begin towards the end of 2020 to scope out the SAM Programme for 2021/22.

Directorate	
Team	
Subspecialty	
Current Situation	
Staffing Establishment	
Vacancies	
Backlog (number of patients)	
Estimated pent-up demand (March to Sep)	
Total demand by Sep 2020	
Restarting the Service and Managing Demand	
How are patients being prioritised (include documented triage and clinical validation)	**Service should use the template set out in *appendix 1* or similar as approved by the Oversight and Scrutiny Group**
Total number of patients triaged as priorities	**???**
Risk assessment for those patients not deemed a priority	**Service should use the template set out in *appendix 2* or similar as approved by the Oversight and Scrutiny Group**
Outcome of Risk Assessment: **Total added to priority list:** **Total deferred:** **Total discharged:**	 **???** **???** **???**
Total number of patients on the priority waiting list:	**???**
When do you plan to restart this service?	
Is restarting this service contingent on other parts of the system eg Covid19 testing, workplace safety?	
What is the impact of restarting the service on other aspects of the system? **Primary Care** **Community Health** **Social Care, including those not delegated to the Partnership** **Acute Care** **Mental Health**	

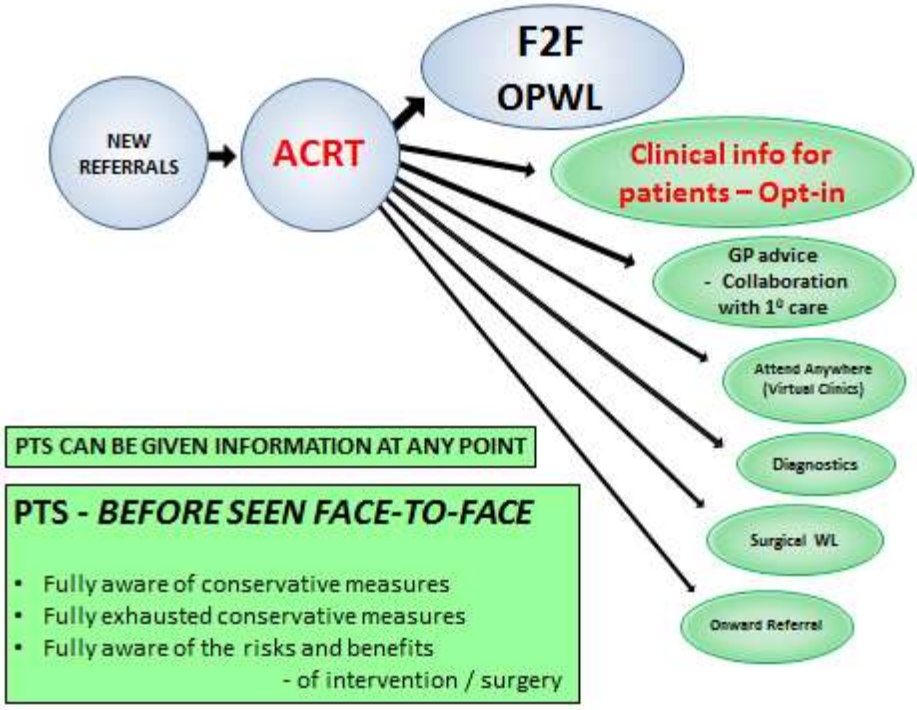
Third Sector **Independent Sector** **Regional Partners**	
How have staff and staff side been involved in developing plans for re-starting the service?	
How have the voices and experiences of local people shaped this plan for re-starting the service?	
What plans are in place for engaging, involving and consulting with the public about re-starting the service?	
Anticipated Performance of Current Service Model	
Describe how the current service model: • **Protects or enables rapid availability of Covid-19 capacity:** • **Supports patient and staff safety:** • **Maintains strict Infection Control measures:** • **Ensure Covid-19 Screening and Testing in line with National Policy:**	• **???** • **???** • **???** • **???**
Planned capacity for; **July** **August** **Sep**	
Anticipated Backlog at End September 2020	**???**
Projected Referrals Oct 20 – Mar 21 **Oct** **Nov** **Dec** **Jan** **Feb** **Mar**	**Current Planned Capacity Oct 20 – Mar 21** **Oct** **Nov** **Dec** **Jan** **Feb** **Mar**
Projected Backlog at End Mar 21	**????**

Projected performance against service standards at end Mar 21	**????**
Projected measures of service quality at end Mar 21	**????**
Projected service budget position at end of Mar 21	**????**
Equality and Diversity Impact Assessment of restarting the Service	
Assessment of Service Risk	**Service should use the template set out in *appendix 3***
Opportunities to Modernise Service Model	
What are the key lessons for the service from the Covid-19 experience?	**Service should use the template set out in *appendix 4* or similar as approved by the Oversight and Scrutiny Group**
What are the opportunities for service redesign arising from this? Please describe.	
What are your proposals for service redesign?	
Is this redesign contingent on other parts of the system eg Covid19 testing, workplace safety?	
What is the impact of this redesign on other aspects of the system? **Primary Care** **Community Health** **Social Care, including those not delegated to the Partnership** **Acute Care** **Mental Health** **Third Sector** **Independent Sector** **Regional Partners**	
How have staff and staff-side been involved	

in developing plans for service redesign?	
How will the voices and experiences of local people shape the plan for redesigning the service?	
What plans are in place for engaging, involving and consulting with the public about the redesign of the service?	
Describe how the proposed service model: • **Protects or enables rapid availability of Covid-19 capacity:** • **Supports patient and staff safety:** • **Maintains strict Infection Control measures:** • **Ensure Covid-19 Screening and Testing in line with National Policy:**	• **???** • **???** • **???** • **???**
What support will you need to deliver this?	
Anticipated Impact of Service Modernisation	
What will the impact be on planned service capacity? **Oct** **Nov** **Dec** **Jan** **Feb** **Mar**	
What will the anticipated impact be on projected backlog at 31 Mar 21?	
What will the anticipated impact be on projected performance against service standards at end Mar 21	
What will the anticipated impact be on projected measures of service quality at end Mar 21	
What will the anticipated impact be on projected service budget position at end of Mar 21	

Equality and Diversity Impact Assessment of the Service Redesign	
Assessment of Risk	

Appendix 1 – Active Clinical Referral Triage Template

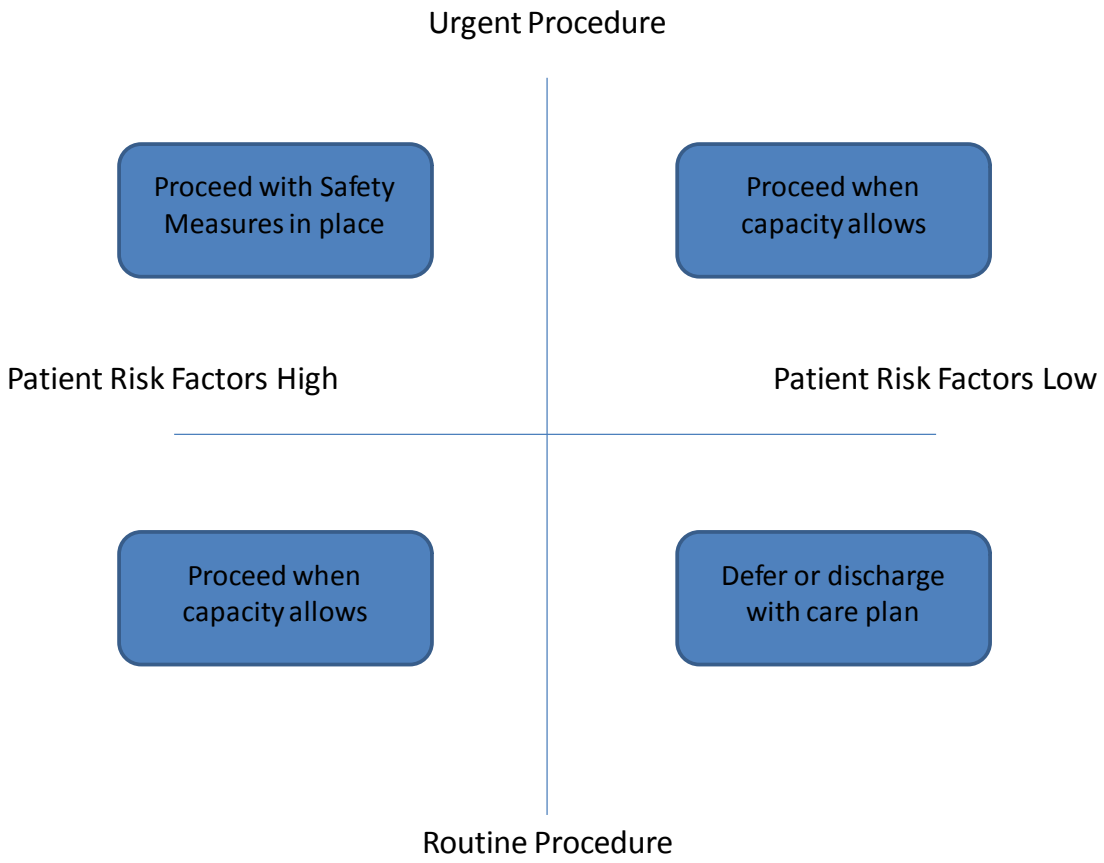


PTS CAN BE GIVEN INFORMATION AT ANY POINT

PTS - *BEFORE SEEN FACE-TO-FACE*

- Fully aware of conservative measures
- Fully exhausted conservative measures
- Fully aware of the risks and benefits
  - of intervention / surgery

Appendix 2 – Patient Risk Assessment



Appendix 3 – Service Risk Assessment

RISK DESCRIPTOR

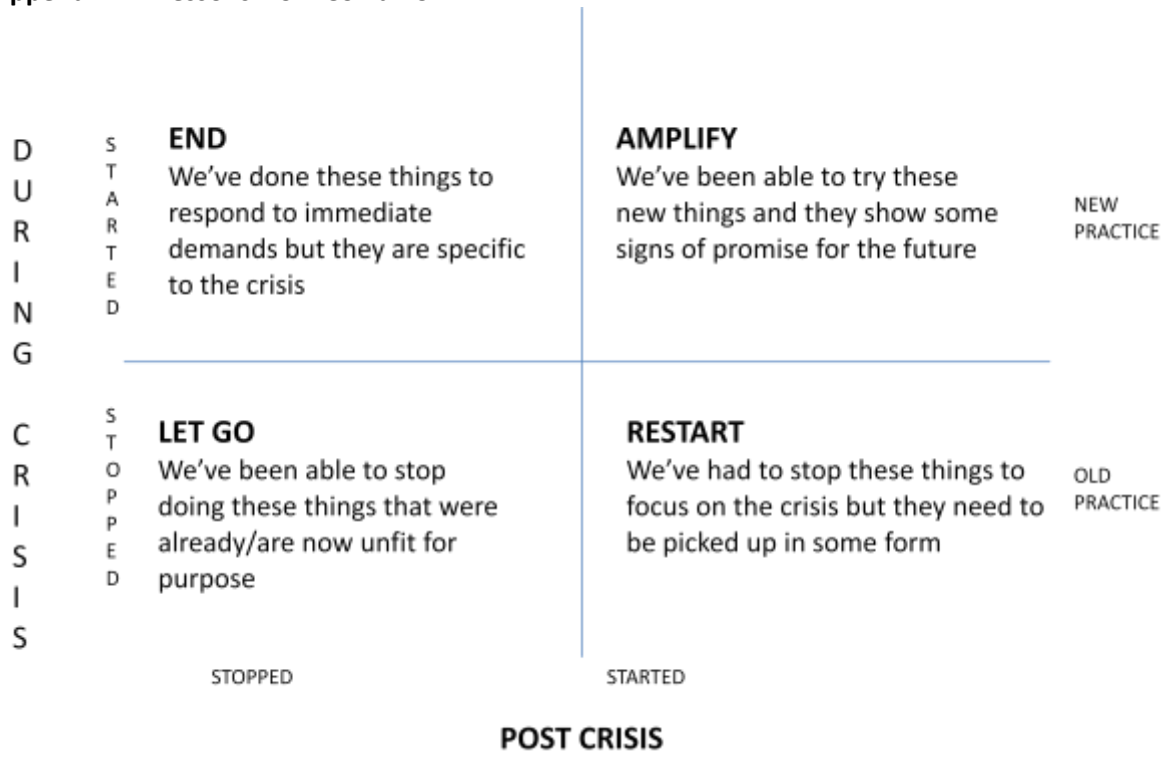
Risk and Threat Assessment (click for dropdown option and complete all categories)

Business	Choose an item.
Clinical	Choose an item.
Staff	Choose an item.
Reputation	Choose an item.

RISK CALCULATION (click on the box for the level of risk using descriptors as the link below)

LIKELIHOOD	IMPACT 1	2	3	4	5
5	5 ☐	10 ☐	15 ☐	20 ☐	25 ☐
4	4 ☐	8 ☐	12 ☐	16 ☐	20 ☐
3	3 ☐	6 ☐	9 ☐	12 ☐	15 ☐
2	2 ☐	4 ☐	6 ☐	8 ☐	10 ☐
1	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Appendix 4 – Lessons from Covid-19



Prioritization Matrix for SAM Projects

Criteria	Prompts	Weight	Project A	Score	
Safe service Delivery	• Improve safety of service provision • Support physical distancing • Reduce risks associated with current model of service provision • Support people to access the right professional at the right time based on their needs (Person Centredness)	5			**INSTRUCTIONS:** 1.Determine the criteria 2.Place your criteria in descending (high to low) order of importance 3.Assign a weight in whole numbers from 1-5 4.Please feel free to add or amend the criteria
Deliverability		5			**Rating:** **1-low** **5-Medium** **9-High**
Efficiency and productivity	• Avoiding waste, including waste of equipment, supplies, ideas, and energy. • Improve performance against service standards / quality indicators • Improve the sustainability of the service. Achieving Best Value. Reducing Unnecessary Variation.	4			
Financial benefits/Cost senstivity	• Address the financial position of the Partnership • Cost savings • Cost avoidance • Return on investment. Achieving Best Value	4			
Clinical Quality, Transformation & Modernisation	• Digitalization of service • Change in service delivery model	4			
Strategic Fit	Extent to which project supports delivery of the Strategic Plan, Operational Plan, etc.	3			
Contributes to Reducing Inequalities		3			
Timescale		2			